STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
OFFICE OF THE STATE EMPLOYER

MEDICAL CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Employee Complete Section I through III, Physician Complete Section IV

Section I. EMPLOYEE IDENTIFICATION

EMPLOYEE'S NAME		SOCIAL SECURITY NUMBER	OFFICE/AGENCY	TKU
HOME ADDRESS (Street, Apt. No.)		HOME PHONE ( )		WORK PHONE ( )
CITY	STATE	ZIP CODE	CLASSIFICATION TITLE AND LEVEL	BARGAINING UNIT

Section II. EMPLOYEE NEEDING LEAVE TO CARE FOR EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER

PATIENT'S NAME (If Other Than Employee)	RELATIONSHIP TO EMPLOYEE ❑ Spouse ❑ Parent ❑ Child

To Be Completed By The Employee Needing Family Care Leave

When leave is needed to care for a seriously ill-family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule. Attach additional sheet, if necessary.

Employee's Signature_____ Date_____

Section III. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the attending physician or practitioner to release the requested information below to my employer regarding my (or my dependent's) physical or mental condition (as to how it will effect my work activity). By signing this release, I understand that I am agreeing that my employer may obtain and use such necessary medical information provided below about me or my dependent's, including information relative to HIV or AIDS, if applicable. This information will only be obtained and used as necessary to process this request for leave of absence. **Note: This information is retained on a confidential basis by the Department in accordance with applicable Civil Service Commission rules and/or collective bargaining agreements and consistent with applicable federal and state law.**

Employee's Signature_____ Date_____

Patient's Signature (If Family Member)_____ Date_____

Section IV. CERTIFICATION OF PHYSICIAN OR PRACTITIONER:

This portion to be filled out by the patient's health care provider for medical leaves for the employee and the family care leaves when the employee is requesting leave to care for the employee's spouse, child, or parent. Physician, please answer all questions.

1. NAME OF PATIENT	2. DATE CONDITION COMMENCED	3. PROBABLE DURATION OF CONDITION & RETURN TO WORK DATE

4. DESCRIBE THE MEDICAL FACTS WHICH SUPPORT YOUR CERTIFICATION.

5. a. **BY PHYSICIAN OR PRACTITIONER:** Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week).

b. **BY ANOTHER PROVIDER OF HEALTH SERVICES, IF REFERRED BY PHYSICIAN OR PRACTITIONER:** Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work less than the employee's normal schedule of hours per day or days per week).

IF THIS CERTIFICATION RELATES TO CARE OF THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 6, 7, AND 8 AND PROCEED TO ITEMS 9 THROUGH 12. OTHERWISE, CONTINUE BELOW.

Check **Yes** Or **No** In The Boxes Below, As Appropriate

6. Is inpatient hospitalization of the employee required? ❑ Yes ❑ No

7. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee) ❑ Yes ❑ No

8. Is employee able to perform work of any kind? ❑ Yes ❑ No

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 9 THOUGH 12 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 13.

9. Is inpatient hospitalization of the family member (patient) required? ❑ Yes ❑ No

10. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ❑ Yes ❑ No

11. After review of the employee's signed statement (See Section II), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include physiological comfort). ❑ Yes ❑ No

12. Estimate the period of time care is needed or the employee's presence would be beneficial.

13. Name of Physician or Practitioner (Please Type or Print)	14. Type of Practice (Specialization, if any)
15. Signature of Physician or Practitioner	16. Date
17. Address of Physician or Practitioner	18. Phone No.
